MEDDAC Regulation 40-30

Medical Services

Sentinel Event Reporting

Headquarters
U.S. Army Medical Department Activity
Fort George G. Meade
2480 Llewellyn Avenue
Fort George G. Meade, MD 20755-5800
23 January 2003

Unclassified

SUMMARY of CHANGE

MEDDAC REG 40-30
Sentinel Event Reporting

Specifically, this revision—

- Has been published in a new format that includes a cover and this "Summary of Change" page.

- Reformats the title page. The Contents section now includes the page numbers that the various chapters and paragraphs begin on.

- Changes "staff duty" and "SD" to read "administrative officer of the day" and "AOD".

Department of the Army
Headquarters
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FOR THE COMMANDER:

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Official:

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History. This is the first revision of this publication, which was originally published on 5 September 2001.

Summary. This regulation establishes policy and procedures for reporting and reviewing sentinel events.

Applicability. This regulation applies to the Headquarters, U.S. Army Medical Department Activity, Fort George G. Meade (MEDDAC) and all outlying U.S. Army health clinics (USAHCs).

Supplementation.
Supplementation of this regulation is prohibited.

Proponent. The proponent of this regulation is the Performance Improvement/Risk Manager (PI/RM).

Suggested improvements. Users of this publication are invited to send comments and suggested improvements, by memorandum, directly to the Commander, U.S. Army Medical Department Activity, ATTN: MCXR-QM, Fort George G. Meade, MD 20755-5800, or to the MEDDAC's Command Editor by fax to (301) 677-8088 or e-mail to john.schneider@na.amedd.army.mil.

Distribution. Distribution of this publication is by electronic medium only.

Contents (Listed by paragraph and page number)

* This publication supersedes MEDDAC Reg 40-30, dated 5 September 2001.

Contents–continued

Chapter 1
Introduction

1-1. Purpose
This regulation establishes responsibilities, policies and procedures for reporting and reviewing sentinel events occurring within the MEDDAC.

1-2. References
Related publications and referenced forms are also listed in appendix A.

1-3. Explanation of abbreviations
Abbreviations used in this memorandum are explained in the glossary.

1-4. Responsibilities
a. *The MEDDAC Commander*. The MEDDAC Commander will—

(1) Foster a cooperative atmosphere for the review of all sentinel events.

(2) Be ultimately responsible for all medical care rendered within the MEDDAC.

(3) With the assistance of the Deputy Commander for Clinical Services (DCCS) and PI/RM, determine if occurrences meet the criteria of sentinel events.

(4) Ensure all sentinel events are reported to Headquarters, U.S. Army Medical Command (MEDCOM) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) within five working days of the known occurrence of the sentinel event; submit a thorough and credible root cause analysis and action plan to JCAHO, via MEDCOM, within 45 days of reporting the sentinel event to MEDCOM. (The plan will identify opportunities for improvement or formulate a rationale for not undertaking such changes and monitoring the effecttiveness, if warranted.)

b. *The DCCS*. The DCCS will—

(1) Upon being notified of an occurrence, contact appropriate members of the clinical and administrative staffs whose expertise may be needed during initial investigation.

(2) Assist the commander to determine whether an occurrence meets the criteria of a sentinel event.

(3) Obtain a review of the incident within two weeks of the known occurrence of an event.

(4) Oversee the implementation of corrective actions, if any.

c. *The PI/RM*. The PI/RM will—

(1) Upon notification of a sentinel event, begin a case file.

(2) Notify the MEDDAC's legal representative at the Office of the Staff Judge Advocate, Fort George G. Meade, of the potential compensable sentinel event.

(3) Under the direction of the DCCS, conduct a root cause analysis of the sentinel event and complete it within two weeks of the known occurrence of the sentinel event. (See chapter 2 for information specific to root cause analyses.)

(4) Present the completed root cause analysis and action plan to the commander and DCCS and place the case on the agenda of the Risk Management Committee for review.

d. *The Administrative Officer of the Day (AOD), Kimbrough Ambulatory Care Center (KACC)*. The KACC AOD will immediately notify the MEDDAC commander and DCCS if there is an occurrence of a possible sentinel event, and make entries on DA Form 1594 (Daily or

Duty Officer's Log) to document that each was contacted "regarding a patient issue."

e. Staff members. Staff members will—

(1) Know what constitutes a sentinel event.

(2) Report any occurrence of a suspected sentinel event immediately and properly; ensure the report, which is made on DA Form 4106 (Quality Improvement/Risk Management Document), contains a factual narrative of the event and a list of witnesses, and that no attempt is made to lay blame for the incident.

(3) Document in the patient's medical record to reflect that an incident occurred. Do not; however, state that an incident report was completed, and secure the record.

(4) Ensure that any equipment suspected to have caused the incident is locked away in a secured area. Do not clean the equipment or alter it in any way. For example, do not change any dial settings or flip any switches.

Chapter 2
Sentinel Events and Action Plans

2-1. What is a sentinel event?

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury especially includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance for serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response.

2-2. Sentinel events subject to review by JCAHO

a. The subset of sentinel events that is subject to review by JCAHO includes any occurrence that meets any of the following criteria:

(1) The event resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

(2) The event was one of the following, even if the outcome was not death or major permanent loss of function:

(a) Infant abduction.

(b) Rape.

(c) Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

(d) Surgery on the wrong patient or on the wrong site.

b. For the minimum scope of root cause analysis for specific types of sentinel events, see table 2-1 (next page).

2-3. Acceptable root cause analyses

A root cause analysis will be considered acceptable if it has the following characteristics:

a. It focuses primarily on systems and processes, not individual performance.

b. It progresses from special causes in clinical processes to common causes in organizational processes.

c. It repeatedly digs deeper by asking "Why?"; then, when answered, "Why?" again, and

so on.

Table 2-1
Minimum scope of root cause analysis for specific types of sentinel events

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

	Suicide (24-hr care)	Medical error	Procedure complication	Wrong site surgery	Treatment delay	Restraint death	Elopement death	Assault, rape, or homicide	Trans-fusion death	Infant abduction
Behavioral assessment process [1]	x					x	x	x		
Physical assessment process [2]	x			x		x	x			
Patient identification process		x		x					x	
Patient observation procedures	x					x	x	x		
Care planning process	x		x			x	x			
Staffing levels	x	x	x	x	x	x	x	x	x	x
Orientation and training of staff	x	x	x	x	x	x	x	x	x	x
Competency assessment and credentialing	x	x	x		x		x	x		x
Supervision of staff [3]		x	x		x				x	
Communication with patient and family	x			x	x	x	x			
Communication among staff members		x	x	x	x	x			x	x
Availability of information		x	x	x	x				x	
Adequacy of technological support		x	x							
Equipment maintenance and management		x	x			x				
Physical environment [4]	x	x	x				x	x	x	x
Security systems and processes	x						x	x		x
Control of medi-cations: storage and access		x								
Labeling of medications		x								

Notes:
1. Includes the process for assessing patient's risk to self (and to others in cases of assault, rape or homicide where a patient is the assailant.
2. Includes search for contraband.
3. Includes supervision of physicians-in-training.
4. Includes furnishings, hardware (such as bars, hooks and rods), lighting and distractions.

d. It identifies changes which could be made in systems and processes, either through re-

design or development of new systems or processes, that would reduce the risk of such events occurring in the future.

e. It is thorough and credible, as described below in paragraphs 2-4 and 2-5, respectively.

2-4. Thorough root cause analyses

To be thorough, a root cause analysis must include—

a. A determination of the human and other factors most directly associated with the sentinel event, and the process(es) and system(s) related to its occurrence.

b. Analysis of the underlying systems and processes through a series of "Why?" questions to determine where redesign might reduce risk.

c. Inquiry into all areas appropriate to the specific type of event as described in table 2-1, above.

d. Identification of risk points and their potential contributions to this type of event.

e. A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist.

2-5. Credible root cause analyses

To be credible, a root cause analysis must—

a. Include participation by the leadership of the organization and by the individuals most closely involved in the processes and systems under review.

b. Be internally consistent (that is, not contradict itself or leave obvious questions unanswered).

c. Provide an explanation for all findings of "not applicable" or "no problem".

d. Include consideration of any relevant literature.

2-6. Action plans

An action plan will be considered acceptable if it—

a. Identifies changes that can be implemented to reduce risk or formulates a rationale for not undertaking such changes.

b. Where improvement actions are planned, identifies who is responsible for implementation, and when the action will be implemented, including any pilot testing and how the effectiveness of the actions will be evaluated.

2-7. Confidentiality of root cause analyses and action plans

All root cause analyses and actions plans are treated as confidential by the MEDDAC and JCAHO.

Chapter 3
Reporting Procedures

3-1. Initial reporting

Any incident that meets or is thought to meet the definition of a sentinel event will be reported immediately. (See the glossary for the definition of sentinel event.)

a. During normal duty hours. The term "normal duty hours" is explained in the glossary.

(1) The staff member who witnesses or becomes knowledgeable of the incident will

immediately notify the PI/RM by calling 301-677-8174 (or 78174 if calling from a military telephone on-post).

(2) The PI/RM will then immediately notify the MEDDAC commander and DCCS.

(3) The staff member having the most knowledge of the incident, which may not be the same staff member who reported the incident, will complete DA Form 4106, and turn it to the PI/RM within 24 hours of the incident. DA Form 4106 is available on FormFlow and can be completed electronically and hand delivered.

b. After normal duty hours. The term "after normal duty hours" is explained in the glossary.

(1) The staff member who witnesses or becomes knowledgeable of the incident will immediately notify the SD by calling 301-677-8741 (or 78741 if calling from a military telephone on-post).

(2) The SD will make an entry on DA Form 1594 regarding the report of the incident, them immediately notify the MEDDAC commander and DCCS that a perceived sentinel event has occurred and provide them the details, as he or she knows them.

(3) The DCCS will then notify the PI/RM of the incident.

(4) The staff member having the most knowledge of the incident, which may not be the same staff member who reported the incident, will complete DA Form 4106, and turn it to the PI/RM within 24 hours of the incident. DA Form 4106 is available on FormFlow and can be completed electronically.

3-2. Facility reporting

a. When there has been a sentinel event, the PI/RM will initiate an investigation of the incident and complete a root cause analysis 30 working days after the occurrence. The PI/RM will coordinate the investigation and, upon it's completion, forward the results to the MEDDAC commander and DCCS for comment and approval of recommended changes, if any.

b. The case will then be presented to the Risk Management Committee. If the committee concludes that a specific provider(s) are directly involved in a breach of standard of care resulting in a sentinel event, information will be referred to the Credentials Committee for action as appropriate.

Appendix A
References

Section I
Required Publications
This section contains no entries.

Section II
Related publications

AR 310-25
Dictionary of United States Army Terms

AR 310-50
Authorized Abbreviations, Brevity Codes, and Acronyms

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Sentinel Event Policy, July 1998.l

The Manual for Ambulatory Care Centers, JCAHO

Section III
Prescribed Forms

This section contains no entries.

Section IV
Referenced Forms

DA Form 1594
Daily Staff Journal or Duty Officer's Log

DA Form 4106
Quality Improvement/Risk Management Document

Glossary
Section I

Abbreviations

AOD
administrative officer of the day

DCCS
Deputy Commander for Clinical Services

JCAHO
Joint Commission on Accreditation of Healthcare Organizations

KACC
Kimbrough Ambulatory Care Center

MEDCOM
U.S. Army Medical Command

MEDDAC
U.S. Army Medical Department Activity, Fort George G. Meade

PI/RM
Performance Improvement/Risk Manager

Section II
Terms

After normal duty hours
Monday-Friday (1600-0730), Saturdays, Sundays, and all federal holidays and training holidays falling on a weekday (Monday-Friday).

Normal duty hours
Monday through Friday, 0730-1600, except federal holidays and training holidays.

Root cause analysis
A process for identifying the basic and casual factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.